

# ILLINOIS FARM BUREAU® RURAL NURSE PRACTITIONER SCHOLARSHIP APPLICATION FORM

NAME:		HOME COUNTY:	
HOME ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> <span>STREET OR RURAL ROUTE</span> <span>CITY</span> <span>STATE</span> <span>ZIP</span> </div>			
TELEPHONE: (     )		Email: _____	
BIRTHDATE:     /     / <div style="display: flex; justify-content: space-around; font-size: x-small; margin-top: 2px;"> <span>MONTH</span> <span>DAY</span> <span>YEAR</span> </div>		NO. YEARS RESIDING IN IL: _____	
SOCIAL SECURITY NO: _____			
EMPLOYER NAME: _____			
ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> <span>STREET</span> <span>CITY</span> <span>STATE</span> <span>ZIP</span> </div>			
IF MARRIED, LIST SPOUSE'S NAME AND OCCUPATION: _____			
NAME OCCUPATION _____			
NUMBER OF CHILDREN: _____		LIST AGES OF CHILDREN: _____, _____, _____, _____, _____.	

ACADEMIC HISTORY:	
CONTACT YOUR SCHOOL AND HAVE THEM SEND US A TRANSCRIPT.	
BASIC NURSING EDUCATION: _____ <div style="text-align: right; font-size: x-small; margin-top: 2px;">NAME OF INSTITUTION</div>	
SCHOOL ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: x-small; margin-top: 2px;"> <span>STREET</span> <span>CITY</span> <span>STATE</span> <span>ZIP</span> </div>	
YEAR GRADUATED: _____	ACADEMIC CREDENTIAL: <input type="checkbox"/> ADN, <input type="checkbox"/> DIPLOMA, <input type="checkbox"/> BSN, <input type="checkbox"/> OTHER.

OTHER EDUCATION:		
NAME OF INSTITUTION _____		
SCHOOL ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: x-small; margin-top: 2px;"> <span>STREET</span> <span>CITY</span> <span>STATE</span> <span>ZIP</span> </div>		
YEARS ATTENDED: _____	YEAR GRADUATED: _____	DEGREE RECEIVED: _____
MAJOR: _____		
NAME OF INSTITUTION _____		
SCHOOL ADDRESS: _____ <div style="display: flex; justify-content: space-between; font-size: x-small; margin-top: 2px;"> <span>STREET</span> <span>CITY</span> <span>STATE</span> <span>ZIP</span> </div>		
YEARS ATTENDED: _____	YEAR GRADUATED: _____	DEGREE RECEIVED: _____
MAJOR: _____		

## EMPLOYMENT HISTORY:

LIST ALL PLACES YOU HAVE BEEN EMPLOYED, JOB TITLE AND DATES OF EMPLOYMENT.  
LIST IN REVERSE CHRONOLOGICAL ORDER BEGINNING WITH YOUR PRESENT EMPLOYER.

YEAR	FROM TO	
_____ MONTH YEAR	_____ MONTH YEAR	
EMPLOYER		APPLICANT'S JOB TITLE
ADDRESS: _____		
_____ STREET CITY STATE ZIP		
YEAR	FROM TO	
_____ MONTH YEAR	_____ MONTH YEAR	
EMPLOYER		APPLICANT'S JOB TITLE
ADDRESS: _____		
_____ STREET CITY STATE ZIP		
YEAR	FROM TO	
_____ MONTH YEAR	_____ MONTH YEAR	
EMPLOYER		APPLICANT'S JOB TITLE
ADDRESS: _____		
_____ STREET CITY STATE ZIP		

ILLINOIS REGISTERED NURSE LICENSE NUMBER:

LIST PROFESSIONAL AND COMMUNITY ORGANIZATIONS AND ACTIVITIES:

HAVE YOU APPLIED FOR ADMISSION TO A NURSE PRACTITIONER PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE APPLIED: _____	
ARE YOU ACCEPTED: <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, INCLUDE A COPY OF THE ACCEPTANCE LETTER.)	
NAME OF UNIVERSITY: _____	
SCHOOL ADDRESS: _____	
_____ STREET CITY STATE ZIP	
IF NO, WHEN WILL YOU BE NOTIFIED OF ACCEPTANCE? _____	
DATE	
HAVE YOU APPLIED OR RECEIVED ANY SCHOLARSHIPS THAT REQUIRES A SERVICE OBLIGATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SCHOLARSHIP PROVIDER AND LENGTH OF SERVICE OBLIGATION. _____	
WILL YOU SIGN AN AGREEMENT TO PRACTICE IN A RURAL* COUNTY IN ILLINOIS FOR A PERIOD OF TWO YEARS FOR EACH YEAR FUNDED AFTER GRADUATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, WHERE WOULD YOU PLAN TO PRACTICE: _____	
COUNTY	
IS THERE AN AGENCY IN THAT COUNTY WHO WOULD BE INTERESTED IN EMPLOYING NURSE PRACTITIONERS: <input type="checkbox"/> YES <input type="checkbox"/> NO	
AGENCY NAME: _____	
IF NO NURSE PRACTITIONER JOB IS AVAILABLE IN THE COUNTY LISTED ABOVE, ARE YOU WILLING TO RELOCATE TO ANOTHER COUNTY: <input type="checkbox"/> YES <input type="checkbox"/> NO	

**PLEASE ENCLOSE WITH THIS APPLICATION FORM A ONE PAGE STATEMENT THAT INCLUDES:**

1. WHY YOU WANT TO BECOME A NURSE PRACTITIONER; AND
2. WHY YOU WANT TO PRACTICE IN A RURAL AREA.

**PLEASE ENCLOSE WITH THIS APPLICATION THREE LETTERS OF PERSONAL RECOMMENDATION.**

**ONE SHOULD BE FROM A REGISTERED NURSE.**

**PLEASE ENCLOSE ANY OTHER INFORMATION THAT YOU BELIEVE IS RELEVANT TO THIS APPLICATION.**

**THE FOLLOWING SIGNATURES MUST BE SECURED BEFORE THIS APPLICATION IS SUBMITTED:**

- |                                    |   |
|------------------------------------|---|
| ✓ REVIEWED BY: _____ COUNTY        | ✓ COMMENTS BY COUNTY FARM BUREAU PRESIDENT: _____ |
| ✓ CFB PRESIDENT'S SIGNATURE: _____ | _____   |
| ✓ APPLICANTS SIGNATURE: _____      | _____   |
|                                    | ✓ DATE OF APPLICATION: _____                      |

**MAIL TO:**

RURAL NURSE PRACTITIONER SCHOLARSHIP PROGRAM  
ILLINOIS FARM BUREAU  
P.O. BOX 2901  
1701 TOWANDA AVENUE  
BLOOMINGTON, IL 61701

FAILURE TO PROVIDE THE REQUIRED  
ATTACHMENTS WILL RESULT IN THE  
DISQUALIFICATION OF APPLICANT IN  
CONSIDERATION FOR THE SCHOLARSHIP.

\*RURAL means a county, not a metropolitan statistical area (MSA) or a county in a MSA but having a population of 60,000 or less